



MISSISSIPPI DIVISION OF  
**MEDICAID**

# Mississippi Medicaid Provider Reference Guide

For Part 208

## Home and Community Based Services

*This is a companion document to the  
Mississippi Administrative Code Title 23  
and must be utilized as a reference only.*

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## HCBS Elderly & Disabled Waiver

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Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

Section 1915(c) of the Social Security Act authorized the Secretary of Health and Human Services to waive certain Medicaid statutory requirements that enable a state to cover an array of Home and Community-Based Services (HCBS) as an alternative to institutionalization. Prior to 1981, the Medicaid program provided little coverage for long-term care services in a non-institutional setting but offered full or partial coverage for such care in an institution. In an effort to address these concerns, the Omnibus Budget Reconciliation Act (OBRA) was enacted, adding section 1915(c) to the Social Security Act. A HCBS waiver offers broad discretion not generally afforded under the State Plan so that the needs of individuals under the State Medicaid plan may be addressed.

Home and Community-Based Services is an optional benefit under the state's Medicaid program. If an individual is not Medicaid eligible at the time of the HCBS application, Medicaid coverage for HCBS services may be possible for the individual if they meet the medical and eligibility criteria for the specific waiver program, along with the financial criteria for Medicaid coverage.

Waiver provider's participation in the Mississippi Medicaid program is entirely voluntary. However, does choose to participate in Medicaid, the provider must accept the Medicaid if a provider payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. DOM does not cover telephone contacts/consultations or missed/cancelled appointments and providers may not bill beneficiaries for these services.

The Division of Medicaid (DOM) is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.

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## Eligibility

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Clinical eligibility for waiver services will be determined through the utilization of a comprehensive pre-admission screening tool that encompasses the following areas: activities of

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daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, client behaviors, medical conditions, and medical services. Pre-admission screening data will be entered into a scoring algorithm that will generate a numerical score. The score will be compared to a set numerical threshold that determines eligibility. Those scores equal to or above the set numerical threshold will be deemed clinically eligible. Refer to Administrative Code Part 207 Chapter 1 for Long Term Care/Pre-Admission Screening policy. Nursing Home level of care must be certified by a physician. The level of care must be re-evaluated every twelve (12) months at a minimum.

It is the responsibility of all waiver providers to check the beneficiary's eligibility status. The eligibility status must be checked at least monthly, or when deemed necessary.

Beneficiaries enrolled in the Elderly & Disabled Waiver cannot reside in a licensed personal care home and are prohibited from receiving additional Medicaid services through hospice, nursing facility, and/or another waiver program.

## Provider Enrollment

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### General Terms and Conditions

1. Provider agrees to deliver services and the Division agrees to pay for services as set forth in their agreement.
2. Provider agrees to make available to appropriate state and federal personnel, during regular business hours, all necessary records relating to services performed. Provider agrees to maintain such records for a period of five (5) years.
3. Provider agrees to submit claims for reimbursement in accordance with instructions from the Division or its fiscal agent. Provider is responsible for the validity and accuracy of claims submitted.
4. Provider agrees to provide transportation services without regard to race, color, religion, sex, national origin, or handicap.
5. Provider agrees to abide by federal and state laws and regulations affecting delivery of services, including use of safety belts.
6. Provider agrees to accept as payment in full the amount paid by Medicaid for claims submitted for payment under that program.
7. Provider understands that payment of claims will be from federal and state funds and any falsification or concealment of material fact may be prosecuted under federal and State laws.

8. Provider will take no action that would circumvent or deny freedom of choice to Medicaid beneficiaries under the Medicaid program.
9. Provider agrees to bill only those claims to Medicaid that have been administered by the provider to an eligible Medicaid HCBS E&D Waiver beneficiary.
10. Provider will refrain from offering or purporting to give any reimbursement, premium, or other free merchandise as a trade inducement to a Medicaid beneficiary.
11. Provider is an independent provider and Medicaid has no liability for negligent acts or omissions of the provider.
12. Provider agrees to have a legal driver's license and have a current inspection sticker, current license plate and current liability insurance on the vehicle. The provider agrees that if a beneficiary is in the provider's vehicle when an accident occurs, the provider must notify DOM within twenty-four (24) hours after the accident.
13. Provider agrees to notify the Division verbally and in writing within the first working day after the loss of inspection sticker, license plate, or liability insurance. The provider's agreement is automatically terminated in the event of such loss, expiration, or non-renewal.
14. Payment may be withheld because of irregularity for whatever cause until such irregularity can be adjusted.
15. The provider's agreement is subject to availability of state and federal funds, the cessation or reduction of which, will constitute the voidance of this Agreement.
16. The provider's agreement is not transferrable or assignable by the provider and may be terminated by thirty (30) days written notice by either party, with the exception of Paragraph 13.
17. In the event funds have been overpaid or disallowed, the provider shall repay to the Division the full amount of the overpayment or disallowance on terms mutually agreeable to the Division and the provider.
18. Provider will not disclose any Medicaid beneficiary information except in connection with providing transportation services or submitting a claim for providing such services, or as otherwise authorized by the Division.
19. The provider agrees to conduct a criminal background check and obtain a motor vehicle report (MVR) on all drivers at least yearly along with a check of the Mississippi Sex Offenders registry. The provider must obtain this documentation on all drivers employed by the agency. Records must be retained in the employee personnel file.

To bill for an hour of ET service, the ET provider must provide at least forty-five (45) minutes of services.

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## Freedom of Choice

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Elderly and Disabled Waiver program will not restrict a beneficiary's freedom to choose providers. During the initial enrollment period and upon annual recertification, the beneficiary will be provided with a list of participating waiver providers, and the beneficiary may select the providers they want to deliver services. After services have been initiated, the beneficiary may at any time request/discuss a change in services with the case manager.

When the service amounts, frequencies, duration, and scope are reduced, denied, or terminated, the beneficiary will be provided written notice of recourse/appeal procedures within ten (10) calendar days of the effective reduction, termination, or denial of services as specified in Section 65.12, Due Process Protection.

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## Referral Process

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The number of beneficiaries enrolled in the E&D Waiver program is limited. Availability is based on program attrition/growth. Two waiting lists are maintained for the E&D Waiver program.

### **PDD E&D Referral List**

The Mississippi Planning and Development Districts/Area Agencies on Aging maintain the PDD E&D Referral List for individuals who are not residing in a nursing facility and who wish to apply for the E&D Waiver Program. An individual may apply for waiver services when his/her name rises to the top of the list.

### **Billy A. Referral List**

The Bureau of Long Term Care, Division of Medicaid, maintains the "Billy A. Referral List." An individual on this list must currently reside in a nursing facility, must wish to apply for the E&D Waiver program, and must have answered "yes" to Q1A in the CMS Case Mix Survey for second quarter 2004. An individual may apply for waiver services when his/her name rises to the top of the list. A specific number of the total E&D Waiver slots must be maintained annually for this referral group.

If a qualified Billy A. referral is unable to transition out of the nursing facility to the E&D Waiver within six (6) months and one (1) week of slot availability, the reason will be documented and the referral file may be closed.

Billy A. Referral case files may be closed for any of the following reasons:

- The applicant is unable to transition from the nursing facility to the community at the end of six (6) months and (1) one week following his or her application date.
- It is determined that the applicant is not eligible for Medicaid and/or the E & D Waiver Program.
- The applicant informs DOM HCBS staff that he/she is no longer interested in moving to the community.
- The applicant dies.
- The applicant leaves the nursing facility without assistance from the Mississippi Department of Rehabilitation Services (MDRS)/Office of Special Disability Programs (OSDP).

## Prior Approval/Physician Certification

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### **Pre-Admission Screening (PAS) Tool**

Clinical eligibility for waiver services will be determined through the utilization of a comprehensive pre-admission screening tool which encompasses the following areas: activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, client behaviors, medical conditions, and medical services. Pre-admission screening data will be entered into a scoring algorithm which will generate a numerical score. The score will be compared to a set numerical threshold which determines eligibility. Those scores equal to or above the set numerical threshold will be deemed clinically eligible. The PAS will generate a Summary and Physician Certification page that must be signed by the physician.

After the applicant has made an Informed Choice, understands the criteria for the waiver, and meets clinical eligibility, as determined by the PAS score, the application along with the Plan of Care (POC), which includes all of the service needs of the applicant, will be forwarded electronically.

Refer to Administrative Code Part 207 Chapter 1 for Long Term Care/Pre-Admission Screening (PAS) policy.

### **Plan of Care**

The Plan of Care form is completed by the case manager. This form, in conjunction with the Pre-Admission Screening (PAS) Tool, contains objectives, types of services to be furnished, and frequency of services. The form must be submitted to the Division of Medicaid, Division of LTC/HCBS.

### **Admitted and Discharged Form**

The Admitted and Discharged form is used to admit and discharge a beneficiary into and from the Home and Community-Based Services waiver program. It must be completed at the time of the initial certification into the program, at each recertification, and anytime there is a change in the beneficiary's status.

DOM HCBS staff will review/process the documents. If approved, an enrollment date will be established. The Pre-Admission Screening (PAS) Tool and the Plan of Care will be returned to the case management provider to retain as part of the case record.

## **Quality Management**

The quality management strategy for the waiver includes the following:

- Level of care need determination consistent with the need for institutionalization
- Plan of care consistent with the beneficiary's needs
- Providers who meet the provider specifications of the CMS approved waiver, including licensure/certification requirements
- Critical event/incident reporting mechanism for beneficiaries and caregivers (for reporting concerns/incidents of abuse, neglect, and exploitation)
- State (DOM) retention of administrative authority over the waiver program
- State (DOM) financial accountability for the waiver program

Only DOM can initiate, in writing, any interpretation or exception to Medicaid rules.

## **Documentation/Record Maintenance**

All providers participating in the Medicaid program are required to maintain legible, accurate, and complete records that disclose and justify the services rendered and billed under the program and upon request, make these records available to representatives of DOM in substantiation of any and all claims. These records must be maintained a minimum of five (5) years to comply with all state and federal regulations and laws. Statistical and financial data supporting a cost report must be maintained for at least five (5) years from the date the cost report (or amended cost report, or appeal) is submitted to DOM.

Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect requirements set forth in the waiver. In addition, waiver providers are required to submit copies

of all service logs/documentation of visits, along with a copy of their billing for each waiver beneficiary served, to the individual's case manager no later than the 15th of the following month in which the service was rendered. The case manager may make an initial verbal request for missing documentation and billing verification from the waiver provider, allowing ten (10) working days for the information to be received. If the information is not provided within the allotted time, the case manager or case management supervisor may make a second verbal request allowing an additional ten (10) working days for the information to be received. If the information is still not received, the third request must be made by the case management supervisor in writing and copied to the HCBS Division Director. The written request should reference the dates that the first and second requests were made and the name of the person to whom the request was made. An additional ten (10) days must be allowed for the provider to submit the required missing documentation. The letter should indicate that no further referrals will be made to the provider until all required documentation is received. If the information is still not received, the HCBS Division Director will determine appropriate action.

If the provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to DOM any money received from the Medicaid program for any such non-substantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.

A provider who knowingly or willfully makes or causes to be made, a false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties, as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

## Reimbursement

Reimbursement for waiver services can be requested no earlier than the first day of the month following the month in which services were rendered. (Example: services provided in June, cannot be billed before July 1.)

Covered services under the Elderly & Disabled Waiver are reimbursed according to reimbursement methodology listed below.

Service	Code	Modifier	Billing Unit
Case Management	T2022	U1	Monthly
In-Home Respite	S5150	U1	15 min. unit
Institutional Respite	S5151	U1	Daily
Adult Day Care	S5102	U1	Daily
Homemaker Services	S5130	U1	15 min. unit
Home Delivered Meals	S5170	U1	Per meal

Escorted Transportation	T2001	U1	Hourly
Transition Assistance	T2038	U1	One-time initial expense per lifetime up to \$800.00

Extended Home Health services will be paid in accordance with the Home Health reimbursement policy. Refer to Administrative Code part 215 Chapter 1 Rule 1.9.

## HCBS Independent Living Waiver

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid (DOM), Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

Section 1915(c) of the Social Security Act authorized the Secretary of Health and Human Services to waive certain Medicaid statutory requirements that enable a state to cover an array of Home and Community-Based Services (HCBS) as an alternative to institutionalization. Prior to 1981, the Medicaid program provided little coverage for long-term care services in a non-institutional setting but offered full or partial coverage for such care in an institution. In an effort to address these concerns, the Omnibus Budget Reconciliation Act (OBRA) was enacted, adding section 1915(c) to the Social Security Act. A HCBS waiver offers broad discretion not generally afforded under the State Plan so that the needs of individuals under the State Medicaid Plan may be addressed.

Home and Community-Based Services is an optional benefit under the state's Medicaid program. If individuals are not Medicaid eligible at the time of the HCBS application, Medicaid coverage for HCBS services may be possible for individuals if they meet the medical and eligibility criteria for the specific waiver program, along with the financial criteria for Medicaid coverage.

Waiver Provider participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. DOM does not cover telephone contacts/consultations or missed/cancelled appointments, and providers may **not** bill beneficiaries for these services.

Through an interagency agreement, the Division of Medicaid and the Mississippi Department of

Rehabilitation Services (MDRS) maintain joint responsibility for the program. The Division of Medicaid maintains responsibility for the administration and supervision of the waiver. DOM formulates all policies, rules, and regulations related to the waiver. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. The Mississippi Department of Rehabilitation Services is responsible for operational functions and for maintaining a current MDRS program Medicaid provider number.

## Eligibility

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The Independent Living (IL) Waiver provides services to beneficiaries who, but for the provision of such services, would require the level of care found in a nursing facility. The IL Waiver is a Medicaid home and community-based waiver operated jointly with the Mississippi Department of Rehabilitation Services. The waiver is operated statewide.

Clinical eligibility for waiver services will be determined through the utilization of a comprehensive pre-admission screening tool that encompasses the following areas: activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, client behaviors, medical conditions, and medical services. Pre-admission screening data will be entered into a scoring algorithm that will generate a numerical score. The score will be compared to a set numerical threshold that determines eligibility. Those scores equal to or above the set numerical threshold will be deemed clinically eligible. Refer to Administrative Code part 215 Chapter 1 Rule 1.9 for Long Term Care/Pre-Admission Screening (PAS) policy.

It is the responsibility of all waiver providers to check the beneficiary's eligibility status. The eligibility status must be checked at least monthly, or when deemed necessary.

## Freedom of Choice

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The Independent Living Waiver program will not restrict a beneficiary's freedom to choose providers. When the service amounts, frequencies, duration, and scope are reduced, denied, or terminated, the beneficiary will be provided written notice of recourse/appeal procedures within ten (10) calendar days of the effective reduction, termination, or denial of services as specified in Section 66.11, Due Process Protection.

## Referral Process

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The number of beneficiaries enrolled in the Independent Living (IL) Waiver program is limited. Availability is based on program attrition/growth. Two waiting lists are maintained for the IL program.

### **Billy A. IL Waiver Referral List**

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The Mississippi Department of Rehabilitation Services (MDRS) maintains the Billy A. IL Referral List for individuals who wish to apply for the IL Waiver program. An individual may apply for waiver services when his/her name rises to the top of the list and a slot is available.

### **NF Resident Master List**

The Bureau of Long Term Care, Division of Medicaid, maintains the NF Resident Master List. An individual on this list must currently reside in a nursing facility, must wish to apply for the IL Waiver program, and must have answered “yes” to Q1A in the CMS Case Mix Survey for second quarter 2004. An individual may apply for waiver services when his/her name rises to the top of the list and a slot is available. A specific number/percent of the total IL Waiver slots must be maintained annually for this referral group.

If a qualified Billy A. referral is unable to transition out of the nursing facility to the IL Waiver within six (6) months and one (1) week of application date, the reason will be documented and the referral file may be closed.

Billy A. referral case files may be closed for any of the following reasons:

- The applicant is unable to transition from the nursing facility to the community at the end of six (6) months and (1) one week following his or her application date.
- It is determined that the applicant is not eligible for Medicaid and/or the IL Waiver Program.
- The applicant informs the Independent Living (IL) counselor that he/she is no longer interested in moving to the community.
- The applicant dies.
- The applicant leaves the nursing facility without assistance from the Mississippi Department of Rehabilitation Services (MDRS)/Office of Special Disability Programs (OSDP).

## **Prior Approval/Physician Certification**

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Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver Program. To obtain approval the waiver provider must complete and submit current DOM approved forms as follows:

- Pre-Admission Screening (PAS) Tool

- Plan of Care Form
- Admitted and Discharged Form

### **Pre-Admission Screening (PAS) Tool**

Clinical eligibility for waiver services will be determined through the utilization of a comprehensive pre-admission screening tool which encompasses the following areas: activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, client behaviors, medical conditions, and medical services. Pre-admission screening data will be entered into a scoring algorithm which will generate a numerical score. The score will be compared to a set numerical threshold which determines eligibility. Those scores equal to or above the set numerical threshold will be deemed clinically eligible. The PAS will generate a Summary and Physician Certification page that must be signed by the physician.

After the applicant has made an Informed Choice, understands the criteria for the waiver, and meets clinical eligibility, as determined by the PAS score, the application along with the Plan of Care (POC), which includes all of the service needs of the applicant, will be forwarded electronically to the Division of Medicaid, Division of LTC/HCBS.

Refer to Administrative Code part 215 Chapter 1 Rule 1.9 for Long Term Care/Pre-Admission Screening (PAS) policy.

### **Plan of Care**

The Plan of Care form is completed by the case manager. This form, in conjunction with the Pre-Admission Screening (PAS) Tool, contains objectives, types of services to be furnished, and frequency of services. The form must be submitted to the Division of Medicaid, Division of LTC/HCBS.

### **Admitted and Discharged Form**

The Admitted and Discharged form is used to admit and discharge a beneficiary into and from the Home and Community-Based Services waiver program. It must be completed at the time of the initial certification into the program, at each recertification, and anytime there is a change in the beneficiary's status.

At the time of initial certification, the DOM Pre-Admission Screening (PAS) Tool, the Plan of Care form, and the Admitted and Discharged form must be completed jointly by the IL counselor AND registered nurse. Forms completed as part of recertification may be completed by the counselor OR the registered nurse.

DOM HCBS staff will review/process all documents. If approved, an enrollment date will be established, appropriate forms will be forwarded to the fiscal agent, and the beneficiary will be locked into the waiver program. DOM HCBS staff will indicate program approval/denial, retain a copy of all forms and forward originals to the IL counselor/registered nurse to retain as part of the case record.

A beneficiary may be enrolled in only one DOM HCBS waiver program at a time. Any request to add services listed on the approved plan of care requires prior approval.

## Covered Services

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### **Case Management**

Case Management services assist beneficiaries in accessing needed waiver and other State Plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services. Case Management services are provided by MDRS IL counselors/registered nurses who meet minimum qualifications listed in the waiver.

Responsibilities include, but are not limited to, the following:

- Initiate and oversee the process of assessment and reassessment of the beneficiary's level of care
- Provide ongoing monitoring of the services included in the beneficiary's individualized plan of care
- Develop, review, and revise the individualized plan of care at intervals specified in the waiver document
- Conduct monthly contact and quarterly face-to-face visits with the beneficiary
- Document all contacts, progress, needs and activities carried out on behalf of the beneficiary
- Certify that personal care attendants meet basic competencies that include both educational and functional requirements

### **Personal Care Attendant**

Personal Care Attendant (PCA) services are support services provided to assist the beneficiary in meeting daily living needs and to ensure optimal functioning at home or in the community, but only in noninstitutional settings. Services must be provided in accordance with the plan of care and may not be purely diversional in nature. Services may include assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. Services may also

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include assistance with preparation of meals, but not the cost of the meals. When specified in the plan of care, services may include housekeeping chores essential to the health of the beneficiary.

Beneficiaries have the option of selecting an individual with whom they are comfortable providing their personal care, but the individual must meet all requirements set forth in the waiver. If the individual does not meet waiver requirements, he/she may be trained through MDRS. Once qualified, the individual may serve as the PCA. The beneficiary also has the option of choosing from a list of available, eligible/qualified personal care attendants. All personal care attendants must meet basic competencies that include both educational and functional requirements. MDRS IL counselors and registered nurses are responsible for certifying and documenting that the PCA meets the requirements.

Personal care services may be furnished by family members provided they are not legally responsible for the individual. The parent (or step-parent) of a minor child, an individual's spouse, the executor of an individual's estate and/or person with durable/medical power of attorney for the individual are considered legally responsible for an individual. Aunts, uncles, grandparents, siblings or parents of adult children who are not legally responsible for the individual may provide services. Family members must meet provider standards, and they must be certified competent to perform the required tasks by the beneficiary and the IL counselor/registered nurse. There must be adequate justification for the relative to function as the attendant, e.g., lack of other qualified attendants in remote areas.

If the participant does not locate/choose a PCA within six (6) months of admission into the waiver, the participant will be discharged from the waiver. Prior to the time of discharge the participant will be informed of other waiver opportunities and community resources available to them.

### **Specialized Medical Equipment and Supplies**

Specialized medical equipment and supplies include devices, controls, or appliances that will enhance the beneficiary's ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes equipment and supplies necessary for life support, supplies and equipment necessary for the proper functioning of such items, and durable and nondurable medical equipment not available under the Medicaid State Plan. The need for/use of such items must be documented in the assessment/case file and approved on the plan of care.

Items reimbursed with waiver funds are in addition to medical equipment and supplies furnished under the Medicaid State Plan. Items not of direct medical or remedial benefit to the beneficiary are excluded.

Equipment and supplies must meet the applicable standards of manufacture, design and installation. MDRS is responsible for certifying and documenting that providers meet the criteria/standards in the waiver document.

Requests for specialized medical equipment/supplies must be evaluated by the MDRS counselor and/or a professional at DOM to determine if an Assistive Technology (AT) evaluation and recommendation is needed. If an AT evaluation is performed, it must be submitted to DOM along with the plan of care and the request for equipment and/or specialized medical supplies. DOM requires a minimum of two (2) competitive bids/quotes for equipment/supplies/environmental adaptations that are not covered under the State Plan and exceed the average cost specified in the approved waiver.

Medicaid waiver funds are utilized as the payor of last resort. The provider must request payment from other payor sources (i.e., Medicare, private insurance, etc.) prior to submitting the claim to DOM.

### **Transition Assistance**

Transition Assistance services are services, provided to a beneficiary currently residing in a nursing facility who wishes to transition from the nursing facility to the Independent Living Waiver program. Transition Assistance is a one-time initial expense required for setting up a household. The expenses must be included in the approved plan of care. Transition Assistance Services are capped at \$800.00 one-time initial expense per lifetime.

#### **1. Eligibility**

To be eligible for Transition Services, the beneficiary must meet all of the following criteria:

- Beneficiary must be a nursing facility resident whose nursing facility services are paid for by DOM
- Beneficiary must have no other source to fund or attain the necessary items/support
- Beneficiary must be moving from a nursing facility where these items/services were provided
- Beneficiary must be moving to a residence where these items/services are normally furnished.

#### **2. Services**

Transition Assistance Services include the following:

- Security deposits required to obtain a lease on an apartment or home

- Essential furnishings such as bed, table, chairs, window blinds, eating utensils, and food preparation items (Items such as televisions, cable TV access or VCR's are not considered furnishings)
- Moving expenses
- Fees/deposits for utilities or service access such as telephone, electricity, etc.
- Health and safety assurances such as pest eradication, allergen control, or one-time cleaning prior to occupancy

All transition services must be essential to (1) ensuring that the individual is able to transition from the current nursing facility, and (2) removing an identified barrier or risk to the success of the transition to a more independent living situation.

### **3. Exclusions**

Transition Assistance is not available for beneficiaries whose stay in a nursing facility is ninety (90) days or less.

### **Environmental Accessibility Adaptation**

Environmental Accessibility Adaptation includes those physical adaptations to the home that are necessary to ensure the health, welfare and safety of the beneficiary, or which enable the beneficiary to function with greater independence, and without which, the beneficiary would require institutionalization.

The need for these adaptations must be identified in the plan of care. Examples include the installation of ramps and grab bars, the widening of doorways, modification of bathroom facilities, and installation of specialized electric and plumbing systems necessary to accommodate medical equipment and supplies.

Exclusions include adaptations or improvements to the home which are not of direct medical or remedial benefit to the beneficiary. Adaptations which add to the square footage of the home are excluded.

Requests for environmental accessibility adaptation must be evaluated by the MDRS counselor and/or a professional at DOM to determine if an Assistive Technology (AT) evaluation and recommendation is needed. If an AT evaluation is performed, it must be submitted to DOM along with the plan of care and the request for environmental accessibility adaptation. DOM requires a minimum of two (2) competitive bids/quotes for equipment/supplies/environmental adaptations that are not covered under the State Plan and exceed the average cost specified in the approved waiver.

Beneficiaries may choose qualified vendors of their choice when receiving environmental accessibility adaptations, specialized medical equipment, and transition services. They may also work with their IL counselor/registered nurse if they want to modify services or change providers.

## Quality Management

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The quality management strategy for the waiver includes the following:

- Level of care need determination consistent with the need for institutionalization
- Plan of care consistent with the beneficiary's needs
- Providers who meet the provider specifications of the CMS approved waiver, including licensure/certification requirements
- Critical event/incident reporting mechanism for beneficiaries and caregivers (for reporting concerns/incidents of abuse, neglect, and exploitation)
- State (DOM) retention of administrative authority over the waiver program
- State (DOM) financial accountability for the waiver program

Only DOM can initiate, in writing, any interpretation or exception to Medicaid rules, regulations, or policies.

## Documentation/Record Maintenance

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All providers participating in the Medicaid program are required to maintain legible, accurate, and complete records that disclose and justify the services rendered and billed under the program, and upon request, make these records available to representatives of DOM in substantiation of any and all claims. These records must be maintained a minimum of five (5) years to comply with all state and federal regulations and laws. Statistical and financial data supporting a cost report must be maintained for at least five (5) years from the date the cost report (or amended cost report, or appeal) is submitted to DOM.

Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect requirements set forth in the waiver. In addition, waiver providers are required to submit copies of all service logs/documentation of visits.

If the provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to DOM any money received

from the Medicaid program for any such non-substantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.

A provider who knowingly or willfully makes or causes to be made, a false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties, as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

## Beneficiary Cost Sharing

Section 1902(a) (14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of receiving Medicaid services. Co-payment may be required of waiver beneficiaries for those services covered under the State Plan.

Beneficiaries enrolled in waiver programs are exempt from co-pay for the additional services offered as a part of the waiver. Additional services are those specifically listed as covered services under the waiver.

Refer to Administrative Code Part 200 Chapter 2 Benefits for information on Medicaid benefits and Chapter 3, Beneficiary Information, for information on beneficiary cost sharing.

## Reimbursement

Reimbursement for waiver services can be requested no earlier than the first day of the month following the month in which services were rendered. (Example: Services provided in June cannot be billed before July 1.)

Covered services under the Independent Living Waiver are reimbursed according to reimbursement methodology listed below.

Service	Code	Modifier	Billing Unit
Case Management	T2022	U2	Monthly
Personal Care Attendant	S5125	U2	15-minute unit
Specialized Medical Equipment and Supplies	T2029	U2	Manually priced/approved (based on a quoted, pre-approved price)
Transition Assistance	T2038	U2	One-time initial expense per lifetime

				up to \$800.00
Environmental Adaptation	Accessibility	S5165	U2	Manually priced/approved (based on a quoted, pre-approved price)

## Due Process Protection

The MDRS IL counselor/MDRS regional supervisor must provide written notice to the beneficiary when any of the following occur:

- Services are reduced
- Services are denied
- Services are terminated

The recourse/appeal procedure notice (Waiver Notice of Action) must contain the following information:

- The dates, type, and amount of services requested
- A statement of the action to be taken
- A statement of the reason for the action
- A specific regulation citation which supports the action
- A complete statement of the beneficiary's/authorized representative's right to request a fair hearing
- The number of days and date by which the fair hearing must be requested
- The beneficiary's right to represent himself or herself or use legal counsel, a relative, friend, or other spokesperson
- The circumstances under which services may be continued if a hearing is requested

Whenever the service amounts, frequencies, duration, and scope are reduced, denied, or terminated, the beneficiary must be provided written notice of recourse/appeal procedures within ten (10) calendar days of the effective reduction or termination of services or within ten (10) calendar days of the decision to deny additional services.

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## Hearings and Appeals

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Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed. The beneficiary/legal representative has thirty (30) days from the date of the notice regarding services to appeal the decision. All appeals must be in writing.

The beneficiary/legal representative is entitled to initial appeal at the local level with the MDRS IL counselor/MDRS regional supervisor. The Notice of Action decision will be explained at that time. The local hearing will be documented and become a permanent part of the beneficiary file.

If the beneficiary/legal representative disagrees with the decision of the local agency, a written request to appeal the decision may be made to the Division of Medicaid. When a state hearing is requested, the MDRS staff will prepare a copy of the case record and forward it to the Division of Medicaid, Bureau of Long Term Care no later than five (5) days after notification of the state level appeal.

The Division of Medicaid, Bureau of Long Term Care will assign a hearing officer. The beneficiary/legal representative will be given advance notice of the hearing date, time, and place. The hearing may be conducted with all parties involved present, or it may be conducted as a conference call (telephone) hearing. The hearing will be recorded.

The hearing officer will make a recommendation, based on all evidence presented at the hearing, to the Executive Director. The Executive Director will make the final determination of the case, and the beneficiary/legal representative will receive written notification of the decision. The final administrative action, whether state or local, will be made within ninety (90) days of the date of the initial request for a hearing. The IL counselor/registered nurse will be notified by the Division of Medicaid to either initiate/continue or terminate/reduce services.

During the appeals process, contested services that were already in place must remain in place, unless the decision is one of immediate termination due to possible danger or racial or sexual harassment of the service providers. The IL counselor/registered nurse is responsible for ensuring that the beneficiary receives all services that were in place prior to the notice of change.

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## HCBS Assisted Living Waiver

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Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor as the single state agency to administer the Medicaid program in Mississippi.

Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain Medicaid statutory requirements that enable a state to cover an array of Home and Community-Based Services (HCBS) as an alternative to institutionalization. Prior to 1981, the Medicaid program provided little coverage for long-term care services in a non-institutional setting but offered full or partial coverage for such care in an institution. In an effort to address these concerns, the Omnibus Budget Reconciliation Act (OBRA) was enacted, adding section 1915(c) to the Social Security Act. An HCBS waiver offers broad discretion not generally afforded under the State Plan so that the needs of individuals under the State Medicaid plan may be addressed.

Home and Community-Based Services is an optional benefit under the state's Medicaid program. If an individual is not Medicaid eligible at the time of HCBS application, Medicaid coverage for HCBS services may be possible for the individual if they meet the medical criteria for the specific waiver program, along with the financial criteria for Medicaid coverage.

A waiver provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. DOM does not cover telephone contacts/consultations or missed/cancelled appointments, and providers may not bill beneficiaries for these services.

The Division of Medicaid (DOM) is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.

All ICF/MR provider agreements are time-limited with the length of time primarily determined by the findings of the survey agency on visits to the facility.

The Mississippi State Department of Health, Division of Health Facilities Licensure and Certification (HFLC) pursuant to federal law regulation, certifies ICF/MR's for participation in the Medicaid program. The duration of a facility's provider agreement will be for the same period of time, initially twelve (12) months or less, as certified or recertified for participation by the survey agency. An exception to this duration of the agreement may occur if the Division of Medicaid has adequate documentation showing proper cause, whereby it may refuse to execute an agreement or may cancel an existing agreement with a certified facility.

When the Division of Medicaid receives the properly executed certification notice from the state or federal survey agency certifying the facility for participation in the Medicaid program, the Division of Medicaid will implement the following:

1. A Mississippi Medicaid Provider Enrollment application and two (2) Provider Agreements will be sent to the facility.
2. The Medicaid Provider Enrollment application and a cover letter that directs all forms will be signed and returned to the fiscal agent along with:
  - a. a copy of the current license of the facility;
  - b. a copy of the Certificate of Need (not required for a participating provider with no changes); and
  - c. a certified copy of the minutes, or other legally sufficient documents, authorizing the person who signs the agreements to do so on behalf of the corporation.
3. When the above material is received, it will be reviewed for completeness, and, if complete, submitted to the Executive Director of the Division of Medicaid for approval or disapproval.
4. If approved, the Executive Director will sign both agreements; one (1) will be returned to the facility and one (1) will be filed in the facility's Medicaid record. The Medicaid Provider Enrollment form will be sent to the fiscal agent so that a Medicaid provider number may be assigned.
5. If the Executive Director disapproves, the facility will be notified in writing. The reasons or the disapproval will be clearly stated, and information will be given on how to appeal the decision.

For further information on Provider Agreements, refer to the Title 23 Administrative Code Part 207, Chapter 3, Rule 3.2 and Part 200, Chapter 4.

Note: Applications and Provider Agreements are available on the website at [www.medicaid.ms.gov](http://www.medicaid.ms.gov)

## Eligibility

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The Assisted Living Waiver provides services to individuals who, but for the provision of such services, would require placement in a nursing facility. Qualified beneficiaries are allowed to reside in a Personal Care Home-Assisted Living (PCH-AL) facility, and Medicaid reimburses for the services received in the facility. The facility must be licensed as a PCH-AL Facility by the Mississippi State Department of Health.

Clinical eligibility for waiver services will be determined through the utilization of a comprehensive pre-admission screening tool that encompasses the following areas: activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, client

behaviors, medical conditions, and medical services. Pre-admission screening data will be entered into a scoring algorithm that will generate a numerical threshold which determines eligibility. Those scores equal to or above the set numerical threshold will be deemed clinically eligible.

It is the responsibility of all waiver providers to check the beneficiary's eligibility status. The eligibility status must be checked at least monthly, or when deemed necessary.

## Provider Enrollment

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Providers interested in becoming Personal Care Home-Assisted Living (PCH-AL) facility providers must complete a proposal package, undergo a facility inspection, and enter into a provider agreement with the Division of Medicaid. All PCH-AL facilities must be certified by the Mississippi State Department of Health (MSDH), Division of Health Facilities Licensure and Certification.

### **Proposal Packet**

A proposal packet may be obtained through the Division of Medicaid. The completed proposal packet and a copy of the MSDH facility license/certification must be mailed back to the Division of Medicaid. DOM staff will review the proposal. If the proposal is accepted, a facility inspection will be scheduled.

### **Facility Inspection**

Upon completion of the proposal packet, DOM staff will inspect the facility to ensure that the facility meets the quality assurance standards adopted by MSDH.

### **Mississippi Medicaid Provider Application**

When all requirements noted above have been satisfied, DOM staff will forward a Mississippi Medicaid Provider Application. The completed application must be returned to the Division of Medicaid. DOM staff will review the application. If approved, the application will be forwarded to the Bureau of Provider/Beneficiary Relations for approval. When all approvals have been obtained, the application will be sent to the fiscal agent.

Upon notification that a provider number has been issued, a welcome letter will be sent to the new provider and the provider will be added to the referral list.

## Freedom of Choice

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Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Section 1902(a) (23) of the Social Security Act provides that "any individual eligible

for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person qualified to perform the service or services required.”

Assisted Living Waiver services will not restrict an individual’s free choice of providers. Each individual found eligible for the waiver will be given free choice of all qualified providers.

## Prior Approval/Physician Certification

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Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver Program. To obtain approval, the following forms must be submitted:

- Pre-Admission Screening (PAS) Tool
- Plan of Care Form
- Admitted and Discharged Form

### **Pre-Admission Screening (PAS) Tool- Assisted Living Waiver Program**

Clinical eligibility for waiver services will be determined through the utilization of a comprehensive pre-admission screening tool which encompasses the following areas: activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, client behaviors, medical conditions, and medical services. Pre-admission screening data will be entered into a scoring algorithm which will generate a numerical score. The score will be compared to a set numerical threshold which determines eligibility. Those scores equal to or above the set numerical threshold will be deemed clinically eligible. The PAS will generate a Summary and Physician Certification page that must be signed by the physician.

Scores less than the set numerical threshold may be approved based on a secondary review by the DOM HCBS staff if all of the following criteria are met:

- Beneficiary has a diagnosis of schizophrenia/other psychoses, major depression, or bipolar disorder
- Beneficiary takes one (1) or more psychotropic medications
- Beneficiary needs or receives medication administration and/or regulation
- Beneficiary PAS score is at least twenty-five (25) and less than forty-five (45)

In addition to the above criteria, the beneficiary may have a history of, or may currently exhibit other behaviors which include, but are not limited to: verbal aggression, physical aggression, resistive behavior, wandering/elopement, inappropriate/unsafe behaviors, self-injury, delusions, hallucinations, manic symptoms and mood swings.

After the applicant has made an informed choice, understands the criteria for the waiver, and meets clinical eligibility, as determined by the PAS score, the application along with the Plan of Care (POC), which includes all of the service needs of the applicant, will be forwarded electronically to the Division of Medicaid, Bureau of LTC.

### **Plan of Care**

The Plan of Care form is completed by the case manager. This form, in conjunction with the Pre-Admission Screening (PAS) Tool, contains objectives, types of services to be furnished, and frequency of services.

### **Admitted and Discharged Form**

The Admitted and Discharged form is used to admit and discharge a beneficiary into and from the Home and Community-Based Services waiver program. It must be completed at the time of the initial certification into the program, at each recertification, and anytime there is a change in the beneficiary's status.

DOM staff will review/process all documents. If approved, an enrollment date will be established, appropriate forms will be forwarded to the fiscal agent, and the beneficiary will be locked into the waiver program. The original of all three (3) forms will be retained by the case manager as part of the original case record.

A beneficiary may be locked into only one waiver program at a time.

## **Covered Services**

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### **Case Management Services**

Case Management Services assist beneficiaries in accessing needed waiver and other State Plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services.

Currently, all case management services are provided through the Division of Medicaid, HCBS section of the Bureau of Long Term Care.

### **Assisted Living Services**

Assisted Living Services may include the following:

**Personal care services**

Services rendered by personnel of the licensed facility to assist beneficiary in performing one or more of the activities of daily living, including but not limited to: bathing, walking, excretory functions, feeding, personal grooming, and dressing.

**Homemaker services**

Services consisting of general household activities including routine household care of beneficiary's residential unit.

**Chore services**

Services needed to maintain the beneficiary's residential unit in a clean, sanitary and safe mode.

**Attendant care services**

Hands-on care, both of a supportive and health-related nature, specific to the needs of a medically stable, physically disabled beneficiary.

**Medication oversight/medication administration**

Services consisting of personnel providing reminders or cues to beneficiaries to take medication, open preset medication containers, and handle/administer medication to the extent permitted under state law. Personnel must operate within the scope of applicable licenses and/or certifications.

**Therapeutic, social, and recreational programming**

Recreation and leisure experiences to help elderly and/or disabled beneficiaries to increase their physical, mental, emotional and social skills.

**Intermittent skilled nursing services**

Nursing care and interventions rendered to the beneficiary as ordered by the physician.

**Transportation**

Services specified in the Plan of Care for transporting beneficiaries to medical appointments.

Transportation services may be provided by the PCH-AL or through the DOM Non-Emergency Transportation (NET) program. Services through NET are available only when the beneficiary has not reached the maximum services limits provided under the State Plan.

**Attendant call system**

Emergency response systems for beneficiaries who are at risk of falling, becoming disoriented, or experiencing some disorder that puts them in physical, mental or emotional jeopardy.

Other individuals or agencies may also furnish care directly, or under agreement with the PCH-AL facility. Care provided by these other entities may supplement services provided by the PCH-AL facility, but they may not be provided in lieu of those provided by the PCH-AL facility.

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**Documentation/Record Maintenance**

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Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect procedures set forth in the waiver Quality Assurance Standards for each service. In addition, PCH-AL facility providers are required to submit copies of all service logs/documentation of visits, along with a copy of their billing for each waiver beneficiary served, to the individual's case manager no later than the 15th of the following month in which the service was rendered. The case manager may make an initial verbal request for missing documentation and billing verification from the waiver provider, allowing ten (10) working days for the information to be received. If the information is not provided within the allotted time, the case manager or case management supervisor may make a second verbal request allowing an additional ten (10) working days for the information to be received. If the information is still not received, the third request must be made by the case management supervisor in writing and copied to the HCBS Division Director. The written request should reference the dates that the first and second requests were made and the name of the person to whom the request was made. An additional ten (10) days must be allowed for the provider to submit the required missing documentation. The letter should indicate that no further referrals will be made to the provider until all required documentation is received. If the information is still not received, the HCBS Division Director will determine appropriate action.

If the provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to DOM any money received from the Medicaid program for any such non-substantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.

A provider who knowingly or willfully makes or causes to be made, a false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties, as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

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## Hearings and Appeals for Denied/Terminated Services

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If the beneficiary/legal representative disagrees with the decision of the local case management team, a written request to appeal the decision may be made to the Division of Medicaid. When a state hearing is requested, the case management team will prepare a copy of the case record and forward it to the Division of Medicaid, Bureau of Long Term Care no later than five (5) days after notification of the state level appeal.

The Division of Medicaid will assign a hearing officer. The beneficiary/legal representative will be given advance notice of the hearing date, time, and place. The hearing may be conducted with all parties involved present, or it may be conducted as a conference call (telephone) hearing. The hearing will be recorded.

The hearing officer will make a recommendation, based on all evidence presented at the hearing, to the Executive Director. The Executive Director will make the final determination of the case, and the beneficiary/legal representative will receive written notification of the decision. The final administrative action, whether state or local, will be made within ninety (90) days of the date of the initial request for a hearing. The case manager will be notified by the Division of Medicaid to either initiate/continue or terminate services.

During the appeals process, contested services that were already in place must remain in place, unless the decision is one of immediate termination due to possible danger or racial, sexual harassment of the service providers. The case manager is responsible for ensuring that the beneficiary receives all services that were in place prior to the notice of change.

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## HCBS Traumatic Brain Injury/Spinal Cord Injury Waiver

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Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid (DOM), Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

Section 1915(c) of the Social Security Act authorized the Secretary of Health and Human Services to waive certain Medicaid statutory requirements that enable a state to cover an array of Home and Community-Based Services (HCBS) as an alternative to institutionalization. Prior to 1981, the Medicaid program provided little coverage for long-term care services in a non-institutional setting but offered full or partial coverage for such care in an institution. In an effort to address these concerns, the Omnibus Budget Reconciliation Act (OBRA) was enacted, adding section 1915(c) to the Social Security Act. A HCBS waiver offers broad discretion not generally

afforded under the State Plan so that the needs of individuals under the State Medicaid Plan may be addressed.

Home and Community-Based Services is an optional benefit under the state's Medicaid program. If individuals are not Medicaid eligible at the time of the HCBS application, Medicaid coverage for HCBS services may be possible for individuals if they meet the medical and eligibility criteria for the specific waiver program, along with the financial criteria for Medicaid coverage.

Waiver Provider participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. DOM does not cover telephone contacts/consultations or missed/cancelled appointments, and providers may not bill beneficiaries for these services.

Through an interagency agreement, the Division of Medicaid and the Mississippi Department of Rehabilitation Services (MDRS) maintain joint responsibility for the program. The Division of Medicaid maintains responsibility for the administration and supervision of the waiver. DOM formulates all policies, rules, and regulations related to the waiver. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. The Mississippi Department of Rehabilitation Services is responsible for operational functions and for maintaining a current MDRS program Medicaid provider number.

## Eligibility

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The Traumatic Brain Injury/Spinal Cord Injury Waiver (TBI/SCI) provides services to beneficiaries who, but for the provision of such services, would require the level of care found in a nursing facility. This waiver is jointly administered by the Division of Medicaid and the Mississippi Department of Rehabilitation Services through an interagency agreement.

It is the responsibility of all waiver providers to check the beneficiary's eligibility status. The eligibility status must be checked at least monthly, or when deemed necessary.

## Freedom of Choice

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Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Section 1902(a) (23) of the Social Security Act provides that "any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person qualified to perform the service or services required."

The Traumatic Brain Injury/Spinal Cord Injury Waiver program will not restrict a beneficiary's freedom to choose providers. The beneficiary has the right to modify or cancel services at any time. The beneficiary should notify the TBI/SCI counselor/registered nurse when a change in providers, services, etc. is requested or made.

When the service amounts, frequencies, duration, and scope are reduced, denied, or terminated, the beneficiary will be provided written notice of recourse/appeal procedures within ten (10) calendar days of the effective reduction, termination, or denial of services.

## Referral Process

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The number of beneficiaries enrolled in the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) program is limited. Availability is based on program attrition/growth. Two waiting lists are maintained for the TBI/SCI program.

### **Billy A. TBI/SCI Waiver Referral List**

The Mississippi Department of Rehabilitation Services (MDRS) maintains the Billy A. TBI/SCI Waiver Referral List for individuals who wish to apply for the TBI/SCI Waiver program. An individual may apply for waiver services when his/her name rises to the top of the list and a slot is available.

### **NF Resident Master List**

The Bureau of Long Term Care, Division of Medicaid, maintains the NF Resident Master List. An individual on this list must currently reside in a nursing facility, must wish to apply for the TBI/SCI Waiver program, and must have answered "yes" to Q1A in the CMS Case Mix Survey for second quarter 2004. An individual may apply for waiver services when his/her name rises to the top of the list and a slot is available. A specific number/percent of the total TBI/SCI Waiver slots must be maintained annually for this referral group.

If a qualified Billy A. referral is unable to transition out of the nursing facility to the TBI/SCI Waiver within six (6) months and one (1) week of application date, the reason will be documented and the referral file may be closed.

Billy A. Referral case files may be closed for any of the following reasons:

- The applicant is unable to transition from the nursing facility to the community at the end of six (6) months and (1) one week following his or her application date.
- It is determined that the applicant is not eligible for Medicaid and/or the TBI/SCI Waiver Program.

- The applicant informs the TBI/SCI counselor that he/she is no longer interested in moving to the community.
- The applicant dies.
- The applicant leaves the nursing facility without assistance from the Mississippi Department of Rehabilitation Services (MDRS)/Office of Special Disability Programs (OSDP)

## Prior Approval/Physician Certification

Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver Program. To obtain approval, the following forms must be submitted to the HCBS Division of the Bureau of Long Term Care:

- Traumatic Brain Injury/Spinal Cord Injury Verification Form
- Pre-Admission Screening (PAS) Tool
- Plan of Care Form
- Admitted and Discharged Form

### **Traumatic Brain Injury/Spinal Cord Injury Verification Form**

The Traumatic Brain/Spinal Cord Injury Verification Form must be completed by the physician. Brain or spinal cord injury that is due to a degenerative or congenital condition, or that results (intentionally or unintentionally) from medical intervention, is excluded.

### **Pre-Admission Screening (PAS) Tool**

Clinical eligibility for waiver services will be determined through the utilization of a comprehensive pre-admission screening tool which encompasses the following areas: activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, client behaviors, medical conditions, and medical services. Pre-admission screening data will be entered into a scoring algorithm which will generate a numerical score. The score will be compared to a set numerical threshold which determines eligibility. Those scores equal to or above the set numerical threshold will be deemed clinically eligible. The PAS will generate a Summary and Physician Certification page that must be signed by the physician.

After the applicant has made an Informed Choice, understands the criteria for the waiver, and meets clinical eligibility, as determined by the PAS score, the application along with the Plan of Care (POC), which includes all of the service needs of the applicant, will be forwarded electronically to the Division of Medicaid, Division of LTC/HCBS.

**Plan of Care**

The Plan of Care form, in conjunction with the PAS contains objectives, types of services to be furnished, and frequency of services.

**Admitted and Discharged Form**

The Admitted and Discharged form is used to admit and discharge beneficiary into and from the Home and Community-Based Services waiver program. It must be completed at the time of the initial certification into the program, at each recertification, and any time there is a change in the beneficiary's status.

At the time of initial certification, the DOM Pre-Admission Screening (PAS) Tool, the Plan of Care form, and the Admitted and Discharged form must be completed jointly by the TBI/SCI counselor AND registered nurse. Forms completed as part of recertification may be completed by the counselor OR the registered nurse.

DOM HCBS staff will review/process all documents. If approved, an enrollment date will be established, appropriate forms will be forwarded to the fiscal agent, and the beneficiary will be locked into the waiver program. DOM HCBS staff will indicate program approval/denial; retain a copy of all forms, and forward originals to the TBI/SCI counselor/registered nurse to retain as part of the case record.

A beneficiary may be enrolled in only one DOM HCBS waiver program at a time. Any request to add or increase services listed on the approved plan of care requires prior approval.

**Covered Services**

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The TBI/SCI Waiver provides the following services:

- Case Management
- Attendant Care
- Respite
- Environmental Accessibility Adaptations
- Specialized Medical Equipment and Supplies
- Transition Assistance

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## Quality Assurance Standards

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Waiver providers must meet applicable quality assurance standards. The standards are part of the waiver document approved by the Centers for Medicare and Medicaid Services. The standards are issued to all new waiver providers, and providers are notified when revisions are made.

Only DOM can initiate, in writing, any interpretation or exception to Medicaid rules, regulations, or policies.

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## Documentation and Record Keeping

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All providers participating in the Medicaid program are required to maintain legible, accurate, and complete records that disclose and justify the services rendered and billed under the program, and upon request, make these records available to representatives of DOM in substantiation of any and all claims. These records must be maintained a minimum of five (5) years to comply with all state and federal regulations and laws. Statistical and financial data supporting a cost report must be maintained for at least five (5) years from the date the cost report (or amended cost report, or appeal) is submitted to DOM.

If the provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to DOM any money received from the Medicaid program for any such non-substantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.

A provider who knowingly or willfully makes or causes to be made, a false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties, as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

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## Beneficiary Cost Sharing

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Section 1902(a) (14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of receiving Medicaid services. Co-payment may be required of waiver beneficiaries for those services covered under the State Plan.

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## Reimbursement

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Covered services under the TBI/SCI Waiver are reimbursed according to reimbursement methodology listed below:

Service	Code Modifier	Billing	Unit
Case Management	T2022	U5	Monthly
Institutional Respite	S5151	U5	Daily
Companion Respite	S5150	U5	15-minute unit
Nursing Respite	T1005	U5	15-minute unit
Attendant Care	S5125	U5	15-minute unit
Environmental Accessibility Adaptation	S5165	U5	Manually priced/approved (based on a quoted preapproved price)
Specialized Medical Equipment and Supplies	T2029	U5	Manually priced/approved (based on a quoted, preapproved price)
Transition Assistance	T2038	U5	One-time initial expense per lifetime up to \$800.00

## Due Process Protection

The MDRS TBI/SCI counselor/MDRS regional supervisor must provide written notice to the beneficiary when any of the following occur:

- Services are reduced
- Services are denied
- Services are terminated

The recourse/appeal procedure notice (Waiver Notice of Action) must contain the following information:

- The dates, type, and amount of services requested
- A statement of the action to be taken
- A statement of the reason for the action
- A specific regulation citation which supports the action
- A complete statement of the beneficiary's/authorized representative's right to request fair hearing
- The number of days and date by which the fair hearing must be requested
- The beneficiary's right to represent himself or herself or use legal counsel, a relative, friend, or other spokesperson
- The circumstances under which services may be continued if a hearing is requested

## Hearings and Appeals

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The beneficiary/legal representative is entitled to initial appeal at the local level with the MDRS TBI/SCI counselor/MDRS regional supervisor. The Notice of Action decision will be explained at that time. The local hearing will be documented and become a permanent part of the beneficiary file. If the beneficiary/legal representative disagrees with the decision of the local agency, a written request to appeal the decision may be made to the Division of Medicaid. When a state hearing is requested, the MDRS staff will prepare a copy of the case record and forward it to the Division of Medicaid, Bureau of Long Term Care no later than five (5) days after notification of the state level appeal.

The Division of Medicaid, Bureau of Long Term Care will assign a hearing officer. The beneficiary/legal representative will be given advance notice of the hearing date, time, and place. The hearing may be conducted with all parties involved present, or it may be conducted as a conference call (telephone) hearing. The hearing will be recorded.

## HCBS Intellectual Disabilities/Developmental Disabilities Waiver

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Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid (DOM), Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

Section 1915(c) of the Social Security Act authorized the Secretary of Health and Human Services to waive certain Medicaid statutory requirements that enable a state to cover an array of Home and Community-Based Services (HCBS) as an alternative to institutionalization. Prior to 1981, the Medicaid program provided little coverage for long-term care services in a non-institutional setting but offered full or partial coverage for such care in an institution. In an effort to address these concerns, the Omnibus Budget Reconciliation Act (OBRA) was enacted, adding section 1915(c) to the Social Security Act. HCBS waivers offer broad discretion not generally afforded under the State Plan so that the needs of individuals under the State Medicaid Plan may be addressed.

Home and Community-Based Service programs are an optional benefit under the state's Medicaid program. If individuals are not Medicaid eligible at the time of the HCBS application, Medicaid coverage for HCBS services may be possible for individuals if they meet the medical and eligibility criteria for the specific waiver program, along with the financial criteria for Medicaid coverage.

Waiver Provider participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. DOM does not cover telephone contacts/consultations or missed/cancelled appointments, and providers may not bill beneficiaries for these services.

The Division of Medicaid (DOM) and the Mississippi Department of Mental Health, Bureau of Intellectual and Developmental Disabilities (DMH/BIDD) maintain joint responsibility for the ID/DD Waiver program. DOM formulates all DOM policies, rules, and regulations related to the Waiver. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. DMH/BIDD is responsible for the operational functions of the Waiver. DMH is responsible for incorporating the following into the provision of covered services: DOM policies, rules and regulations; provisions of the

HCBS ID/DD Waiver approved by the Centers for Medicare and Medicaid Services (CMS); and the Mississippi Department of Mental Health Standards. DOM maintains ultimate authority and responsibility for the administration of the Waiver by exercising oversight over the performance of the Waiver functions by other State and local/regional non-State (if appropriate) and contracted entities. DOM will ensure financial audits of ID/DD Waiver providers are conducted. In the event of any conflict between DOM policies, rules and regulations and the policies, rules and regulations of any other State agency, DOM's policies, rules and regulations shall control for the purpose of determining reimbursement from DOM.

Only DOM can initiate, in writing, any interpretation or exception to Medicaid rules, regulations, or policies.

## Eligibility

Applicants for the ID/DD Waiver must:

- Require a level of care found in an ICF/MR
- Qualify for full Medicaid benefits in one of the following categories:

COE-001	SSI
COE-003	IV-E Foster Children and Adoption Assistance Children
COE-007	Protected Foster Care Adolescents
COE-019	Disabled Child Living at Home Program
COE-025	Working Disabled
COE-026	CWS Foster Children and Adoption Assistance Children
COE-064	HCBS MR-DD
COE-085	Low Income Families and Children Program
COE-087	Children Under Age 6 at 133% Federal Poverty Level
COE-091	Children Under Age 19 100% of Poverty

- Have an intellectual disability, a developmental disability, or autism as defined below:

### **Intellectual Disability**

Intellectual disability is characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. The condition is manifested prior to age eighteen (18). Intellectual disability is the preferred term for the disability historically referred to as mental retardation.

The term intellectual disability covers the same population of individuals who were diagnosed previously with mental retardation in number, kind, level, type, and duration of the disability and

the need for individuals with this disability to receive individualized services and supports. Every individual who is or was eligible for the diagnosis of mental retardation is eligible for a diagnosis of intellectual disability. The low IQ score alone is insufficient for a diagnosis of intellectual disability. It must co-exist with limitations in adaptive behavior. Adaptive behavior refers to those social and practical skills used to effectively function in daily life. Skills include, but are not limited to, communication, social interaction, self-care, money management, and use of transportation. An accurate diagnosis of intellectual disability requires three (3) components: an IQ score of approximately seventy (70) or below, a determination of deficits in adaptive behavior, and manifestation of disability prior to age eighteen (18).

### **Developmental Disability**

In general, the term developmental disability is defined as a severe, chronic disability that is attributable to a mental and/or physical impairment. The condition is manifested before age twenty-two (22) and is likely to continue indefinitely. It results in substantial functional limitations in three (3) or more areas of life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. The individual requires a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of individually planned and coordinated assistance that is life-long or of extended duration.

An individual from birth to age nine (9) who has a substantial developmental delay or specific congenital or acquired condition, may be considered developmentally disabled without meeting all of the criteria described in the previous paragraph if, without services and supports, there is a high probability of meeting those criteria later in life.

### **Severe, Chronic Disability**

Severe, chronic disability is defined as a condition attributable to cerebral palsy or epilepsy or any other condition other than mental illness found to be closely related to mental retardation, because it results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires similar treatment/services. The condition is manifested prior to age twenty-two (22) and is likely to continue indefinitely. The condition results in substantial functional limitations in three (3) or more of the follow major life activities: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living (42 CFR 435.1010).

### **Autism**

A diagnosis of autistic disorder is made when the following criteria from A, B, and C are all met.

- A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):

1. Qualitative impairment in social interaction, as manifested by at least two of the following:
    - a. Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction.
    - b. Failure to develop peer relationships appropriate to developmental level.
    - c. A lack of spontaneous seeking to share enjoyment, interests, or achievements with others (e.g., by a lack of showing, bringing, or pointing out objects of interest).
    - d. Lack of social or emotional reciprocity.
  2. Qualitative impairments in communication as manifested by at least one of the following:
    - a. Delay in or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime).
    - b. In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others.
    - c. Stereotyped and repetitive use of language or idiosyncratic language.
    - d. Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.
  3. Restricted, repetitive, and stereotyped patterns of behavior, interest, and activities, as manifested by at least one of the following:
    - a. Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.
    - b. Apparently inflexible adherence to specific, nonfunctional routines or rituals.
    - c. Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements).
    - d. Persistent preoccupation with parts of objects.
- B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age three (3) years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.
- C. The disturbance is not better accounted for by Rhett's Disorder or Childhood Disintegrative Disorder.

## **Participant Certification/Recertification**

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All participants must be initially certified as needing ICF/MR level of care before services provided through the ID/DD Waiver can begin. Participants must be recertified at least every twelve (12) months thereafter to continue receiving ID/DD Waiver services. ID/DD Support Coordinators are responsible for coordinating the certification/recertification process and for

forwarding the information/documents outlined in the DMH/BIDD Record Guide to DMH/BIDD. DMH/BIDD approves/disapproves all requests for certification and recertification. All documentation is submitted to DOM.

### **Evaluation Summary and Interdisciplinary Recommendations Report**

The initial level of care evaluation for both ID/DD Waiver applicants and ICF/MR applicants is the same. Educational/professional qualifications for evaluators are the same for ID/DD Waiver applicants and applicants for ICF/MR facilities. Evaluations are conducted at one of the Mississippi Department of Mental Health's five (5) comprehensive regional centers (Ellisville State School, Boswell Regional Center, Hudspeth Regional Center, North Mississippi Regional Center, or South Mississippi Regional Center), depending on where the applicant lives. When the evaluation is complete, the Diagnostic Services Department prepares the Evaluation Summary and Interdisciplinary Recommendations Report. The results of the evaluation determine whether the applicant meets ICF/MR level of care. The applicant must require ICF/MR level of care to be eligible for Waiver services. Refer to Administrative Code Part 208 Chapter 5 for Level of Care Evaluation/Reevaluation policy.

### **ID/DD Waiver HCBS Certification of ICF/MR Level of Care (DOM-260-HCBS-ID/DD Form)**

The ID/DD Waiver HCBS Certification of ICF/MR Level of care form may not be dated more than ninety (90) days prior to the lock-in end date for a recertification. Waiver Support Coordinators **may** submit a recertification to the DMH/BIDD beginning 60 days prior to the current lock-in end date, but **must** submit them at least 45 days prior to the current lock-in end date. The participant must be recertified on an annual basis, prior to the current lock-in end date. The ID/DD Waiver HCBS Certification of ICF/MR Level of care form is valid for 364 days. The form, regardless if it is an initial or recertification request, is dated and signed by the Waiver Support Coordinator and the Waiver Support Coordinator Director certifying the participant meets the criteria for ICF/MR level of care. Recertification requests are submitted to DMH/BIDD for approval/denial.

### **Plan of Care (HCBS-ID/DD Waiver Individual Plan of Care Form)**

The Plan of Care (POC) contains objectives, the types of services to be provided, frequency of services and current providers of each approved service. This form is completed by the ID/DD Waiver Support Coordinator. Refer to Administrative Code Part 208 Chapter 05 for Covered Services policy.

The formal comprehensive evaluation conducted by the Diagnostic and Evaluation (D&E) Team is used to identify strengths, needs, preferences and health status. The ID/DD Waiver Support Coordinator meets with the beneficiary and/or legal representative (as appropriate) and anyone else the beneficiary would like to have present, to discuss items identified in the D&E Team's evaluation in addition to anything else the beneficiary might identify. The beneficiary and ID/DD

Waiver Support Coordinator list, arrange, and prioritize all items and areas to be addressed before developing the POC.

After the initial POC is developed, it becomes a “living” document which is reviewed at least quarterly by the ID/DD Waiver Support Coordinator and beneficiary/legal representative. Beneficiaries/legal representatives may request modification and/or cancellation of services at any time. If the beneficiary/legal representative desires a modification and or cancellation of services between quarterly visits, the beneficiary/legal representative may contact the ID/DD Waiver Support Coordinator to request changes to the POC. Request for modifications and/or cancellations are submitted to DMH/BIDD by the ID/DD Waiver Support Coordinator. When a decision is rendered by DMH/BIDD, the ID/DD Waiver Support Coordinator is notified. The ID/DD Waiver Support Coordinator will make any revisions to the POC, including updating start and end dates.

### **ID/DD Waiver Lock-in Request Form (MHP105)**

The ID/DD Waiver Lock-in Request Form (MHP105) is used to notify DOM of an admission, discharge, or recertification of a beneficiary enrolled in the HCBS waiver program. The form is also used to inform DOM when a beneficiary enrolled in the ID/DD Waiver is transferred to the catchment area of another Regional Center. DOM/BMHP staff updates the lock in segment in MMIS system based on information on the MHP105.

### **Submission of Participant Certification/Re-certification File**

The Support Coordinator submits a copy of all applicable forms and information to DMH/BIDD. After DMH/BIDD staff takes action, if needed, applicable forms and supporting documentation are submitted to DOM/BMHP. DOM/BMHP staff updates the MMIS system, if needed, and sends a copy to the appropriate Support Coordinator. The Support Coordinator will retain all original forms as part of the on-site case record. All documents must be readily available for review by DOM/BMHP staff when requested.

## **Reimbursement**

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Reimbursement for Waiver services can be requested no earlier than the first day of the month following the month in which services are rendered. (Example: services provided in June cannot be billed before July 1). Services may only be provided to participants when authorized by the ID/DD Waiver Support Coordinator as part of the approved Plan of Care. All ID/DD Waiver providers must be enrolled as a Mississippi Medicaid Provider and must maintain an active provider number. All ID/DD Waiver providers except those for therapy services and specialized medical supplies must be certified by DMH.

**Detailed procedure code fee schedules for ID/DD Waiver services**

Service	Procedure Code	Second Modifier	Rates	Max. Allowable Units	Provider Type	Place of Service
Behavioral Evaluation Support	H0002	None	<b>\$70.00/hr. ÷ 4 = \$17.50/15 min. unit</b>	10 hrs/yr	W08	12 99
Behavioral Intervention Bachelors Support by	H2019	HN	<b>\$25.00/hr. ÷ 4 = \$6.25/15 min. unit</b>	Max 800 hrs/year	W08	12 99
Behavioral Intervention Masters Support by	H2019	HO	<b>\$35.00/hr. ÷ 4 = \$8.75/15 min. unit</b>			
Day Services - Adults	S5100	None	<b>\$14.28/hr. ÷ 4 = \$3.57/ 15 min. unit</b>	Min ≥ 4 hrs/day, Max = 130 hrs/month	W07 W08	99
Home and Community Supports	S5125	None	<b>\$16.00/hr. ÷ 4 = \$4.00/ 15 min. unit</b>			
HCS – 2 people same location	S5125	UN	<b>\$24.00/hr. ÷ 4 = \$3.00/ 15 min. unit</b>	None	W06 W07	12 99
HCS – 3 people same location	S5125	UP	<b>\$27.00/hr. ÷ 4 = \$2.25/ 15 min. unit</b>			
Occupational Therapy Prior Authorization Required	G0152	None	<b>\$70.00/hr. ÷ 4 = \$17.50/ 15 min. unit</b>	2 hours a wk = 8 units of 15 min increments	T00	12 99
Physical Therapy Prior Authorization Required	G0151	None	<b>\$70.00/hr. ÷ 4 = \$17.50/ 15 min. unit</b>	3 hours a wk = 12 units of 15 min increments	T01	12 99
Pre Vocational Services	T2015	None	<b>\$11.00/hr.</b>	130 hrs/month	W07 W08	99
Residential Habilitation Must Be Age 21 or Older	S5136	None	<b>\$55.00/day</b>	1 unit a day	W07 W08	12
Respite - In Home Companion or Community	S5150	None	<b>\$16.00/hr. ÷ 4 = \$4.00/ 15 min. unit</b>	None	W02 W03 W08	12 99
Respite – ICF/MR	H0045	None	<b>\$264.00/day</b>	30 Days per Cert Period	G2 G7	54
Respite – In Home Nursing	T1005	None	<b>\$23.00/hr. ÷ 4 = \$5.75/ 15 min. units</b>	None	W03 W08	12

Speech Therapy Prior Authorization Required	G0153	None	$\$65.00/\text{hr.} \div 4 =$ <b>\$16.25/ 15 min. unit</b>	3 hours a wk = 12 units of 15 min increments	T02	12 99
Support Coordination	T2022	None	<b>\$125.00/month</b>	1 unit / month		
2 <sup>nd</sup> Level Support Coordination	T2022	TF	<b>\$150.00/month</b>	1 unit / month	W08	12
Supported Employment	H2023	None	$\$25.00/\text{hr.} \div 4 =$ <b>\$6.25/ 15 min. unit</b>			
SE - 2 people same location	H2023	UN	$\$32.00/\text{hr.} \div 4 =$ <b>\$4.00/ 15 min. unit</b>	None	W08 W07	99
SE - 3 people same location	H2023	UP	$\$36.00/\text{hr.} \div 4 =$ <b>\$3.00/ 15 min. unit</b>			

## Beneficiary Cost Sharing

Section 1902(a) (14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of receiving Medicaid services. Co-payment may be required of Waiver beneficiaries for those services covered under the State Plan. Beneficiaries enrolled in Waiver programs are exempt from co-payment for the additional services offered as part of the Waiver. Additional services are those specifically listed as covered services under the Waiver.

Refer to Administrative Code Part 208 Chapter 5 Rule 5.11 for additional information.

## Covered ID/DD Waiver Services

### Support Coordination

ID/DD Waiver Support Coordination is defined as services designed to assist participants in accessing needed Waiver and other State Plan services, as well as needed medical, social, educational, or other services, regardless of the funding source for the services. The service is provided by ID/DD Waiver Support Coordinators. ID/DD Waiver Support Coordinators are responsible for the following activities:

- Developing (along with the participant), reviewing, and revising the participant’s POC as necessary.
- Providing participants with information about qualified providers for the services on the approved POC.
- Forwarding required information to DMH/BIDD for review and approval/denial.

- Notifying applicants of approval/denial of initial enrollment as well as requests for additional services increases in services, recertification, reductions in services, termination of services, and/or discharge from the waiver.
- Ongoing monitoring and documentation of whether the participant's health and welfare is being assured by evaluating the effectiveness of services, waived and non-waived, and participant/legal representative satisfaction with services during phone contacts and face-to-face visits.
- Submitting requests for changes in services on the POC identified during phone contacts and face-to-face visits to DMH/BIDD for approval/disapproval along with supporting documentation. When the POC is returned, the ID/DD Waiver Support Coordinator sends a Notice of Determination to the beneficiary/legal representative within ten (10) days.
- Notifying providers of changes to the POC by sending Service Authorizations within ten (10) days of receipt of determination by DMH/BIDD. If a beneficiary decides to appeal, the provider is notified in writing to continue services that were in place prior to the changes specified in the Service Authorization. The provider will be notified in writing of approved services resulting from the final appeal decision.
- Ongoing assessment of the beneficiary and his/her situation based on information obtained during phone contacts, observations/interactions with the participant during quarterly face-to-face visits, contacts with providers, contacts with family/caregivers, and information acquired for the annual LOC re-evaluation.
- Ongoing monitoring of all services on the POC to ensure they are appropriate/adequate to meet identified needs.
- Ensuring that all services, regardless of funding source, are coordinated to maximize the benefit and to prevent duplication of services.
- Performing all functions necessary for the recertification process.
- Reviewing reports provided by DOM/BMHP to monitor waiver services on the Plan of Care.

### **Respite Care**

Respite Care is defined as services that provide temporary, periodic relief to those persons normally providing the care for an eligible participant who is unable to provide the care themselves. The respite worker provides the care the caregiver would normally provide during that time and may accompany the participant on short outings such as those for exercise, recreation or shopping. Respite services are also available when the usual caregiver is absent or incapacitated due to hospitalization, illness, injury, or death. Respite is designed to be provided on a short-term basis.

Respite services can be provided in the participant's home or private place of residence, a DMH certified community site, or a Medicaid certified ICF/MR.

### **In-Home Respite**

In-home respite services are provided in the participant's home by a Certified Nursing Assistant (CNA), a Licensed Practical Nurse (LPN) or a Registered Nurse (RN).

If services are provided to more than one participant in the same residence, both participants must be immediately related (example: siblings, parent/sibling). The provider must bill separately for each participant.

#### **Types of In-Home Respite:**

- In-Home Respite services may be provided in the beneficiary's home by a Licensed Practical Nurse (LPN) or a Registered Nurse (RN). The need for respite provided by a nurse is dependent upon whether or not the beneficiary requires nursing care in the absence of the primary care giver. Nurses must be licensed according to state law and practice in compliance with the Mississippi Nurse Practice Act and current nursing laws and regulations. Nurses must be employed by an agency certified by MDMH and enrolled as an ID/DD Waiver provider.
- In-Home Respite services may be provided in the beneficiary's home by a Certified Nurse's Aide (CNA). CNA's must be employed by an agency certified by MDMH and enrolled as an ID/DD Waiver provider. CNA's must be supervised by an RN.

Exclusions: The provider may not run personal errands while caring for the participant. Services may not be provided in the home of the respite worker, only in the home of the individual receiving the services.

### **Community Respite**

Community Respite services are provided in a community setting. Community respite is designed to provide primary caregivers a break from constant care giving as well as provide the participant with a safe place to go that will provide scheduled activities to address beneficiary preferences/requirements.

Exclusions: Community Respite cannot be provided overnight and cannot be provided in a private residence. Community Respite cannot be used in place of regularly scheduled day activities such as Supported Employment, Day Services-Adults, or Prevocational Services.

**ICF/MR Respite**

ICF/MR Respite services are provided in a state-licensed ICF/MR facility. ICF/MR respite services may be provided up to thirty (30) days per certification period.

**General Guidelines for Respite**

- In-home and community respite participants may receive other ID/DD Waiver services on the same day of services, but not during the same time period. Participants may receive Day Service-Adults, Prevocational, Supported Employment, Home and Community Supports, PT/OT/ST and/or Behavior Support Intervention.
- Residential habilitation participants are not eligible to receive in-home and community respite services. In-home and community respite services include medication administration and other medical treatments to the extent permitted by State law.
- Training is not provided as a component part of in-home and community respite.
- Participants who live in a group home or staffed residence or who live alone cannot receive in-home or community respite.
- In-home and community respite cannot be provided to someone who is an in-patient of a hospital, nursing facility, or ICF/MR when the in-patient facility is billing Medicare, Medicaid and/or private insurance.

**Residential Habilitation**

Residential Habilitation is defined as services designed to assist the participant with acquisition, retention, or improvement in skills related to living in the community. Services include adaptive skill development, assistance with activities of daily living, community inclusion, transportation and leisure skill development. Habilitation, learning and instruction are coupled with the elements of support, supervision and engaging participation to reflect that of daily living.

General guidelines for Residential Habilitation include the following:

- Residential Habilitation dwellings may be (1) rented, leased or owned by the provider or (2) rented, leased or owned by the participant.
- Staff must be available on site twenty-four (24) hours per day seven (7) days per week. Staff must be able to respond to requests for assistance within five (5) minutes.
- The provider is responsible for providing an appropriate level of services and supports twenty-four (24) hours a day during the hours the participant is not receiving day services or is not at work. The provider is responsible for overseeing the participant's health care needs by assisting with (1) making doctor/dentist/optical appointments, (2)

transporting and accompanying the participant to appointments, and (3) talking with medical professionals if the participant gives permission to do so.

- Residential Habilitation is available to participants who are no longer eligible for educational services based on graduation and/or receipt of a diploma/equivalency certificate or permanent discontinuation of the educational services.
- Transportation service is a component part of Residential Habilitation and is included in the reimbursement rate. Services include transportation to and from job sites, transportation for shopping or other community activities, transportation to leisure events, and transportation to appointments. Providers should not bill separately for transportation services and should not charge participants for these services.
- Participants receiving Residential Habilitation may not receive home and community supports, in-home respite, or community respite services.
- Participants receiving Residential Habilitation may receive Prevocational Services, Day Services-Adult, Supported Employment, Behavior Support/intervention, therapy (OT, PT, and ST) services, and/or Specialized Medical supplies.

### **Day Services-Adults**

Day Services for adults is defined as services designed to assist the participant with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Services focus on enabling the participant to attain or maintain his/her maximum functional level and are coordinated with physical, occupational, and/or speech-language therapies listed if included on the POC. Activities include those that foster the acquisition of skills, greater independence and personal choice.

Day Services for adults take place in a nonresidential setting, separate from the home or facility in which the participant resides. Services are furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, or as specified in the participant's POC. Services are limited to a maximum of one hundred thirty (130) hours per month.

General guidelines for Day Services for adults include the following:

- Meals provided as part of this service do not constitute a “full nutritional regimen” (i.e., three meals per day), but the program must provide a mid-morning snack, a nutritious noon meal, an afternoon snack, and offer choices of food and drink.
- Participants with degenerative conditions and/or those who have chosen to retire may receive services that include supports designed to maintain skills and prevent or slow regression.

- Participants receiving Day Services for adults may also receive educational, Supported Employment, Prevocational services, In-home respite, Community respite, ICF/MR respite, Home and Community Supports, Behavior Support/intervention services, and/or PT/OT/ST if these services are included in the approved POC. None of these services may be received during the same time period, but participants may receive multiple services on the same day. Services may be provided in DMH certified sites and/or in community settings.

Transportation between the participant's place of residence and the service site for community outings is provided as a component part of Day Services for adults. The cost of transportation is included in the rate paid to providers. Providers cannot bill for transportation time to and from the participant's residence but can bill for transportation provided to access the community during the provision of Day Services for adults.

### **Prevocational Services**

Prevocational Services prepare a participant for paid employment. Services address underlying facilitative goals (e.g., attention span, motor skills) which are associated with performing compensated work. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Services are not job task oriented, but instead, are aimed at a generalized result. Services are reflected in the participant's Prevocational Service Plan and are directed to facilitative rather than explicit employment objectives. Services are limited to a maximum of one hundred thirty (130) hours per month.

In Mississippi, Prevocational Services are not otherwise available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Sections 602(16) and (17) of the Individuals with Disabilities Education Act , 20 U.S.C. 1401 (16) and (17).

General guidelines for Prevocational Services include the following:

- The program is not required to provide meals but must have procedures to ensure food/drink is available to anyone who might forget lunch/snacks.
- Personal care/assistance may be a component of Prevocational Services, but it may not comprise the entirety of the service.
- Participants who receive Prevocational Services may be compensated in accordance with applicable federal laws and regulations.
- When a participant earns more than fifty percent (50%) of the minimum wage, the participant, appropriate staff and the ID/DD Waiver Support Coordinator must review the necessity and appropriateness of the services.
- Participants receiving Prevocational Services may also receive educational, Supported Employment and/or Day Services for adults.

- Transportation between the participant's place of residence and the Prevocational Services site and to the sites in the community is provided as a component part of Prevocational Services. The cost of this transportation is included in the rate paid to providers of Prevocational Services. Providers should not bill separately for transportation services and should not charge participants for these services.

### **Supported Employment**

Supported Employment services are intensive, ongoing supports which enable participants for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of disabilities, require supports to perform in a regular work setting. Supported Employment may include assisting the participant to locate a job or developing a job on the participant's behalf.

Supported Employment also includes services and supports to assist the participant in achieving self-employment. Assistance with self-employments includes the following:

- Aiding the participant in identifying potential business opportunities
- Assisting in the development of a business plan, including potential sources of financing and other assistance in developing and launching a business
- Identifying supports necessary for the participant to successfully operate the business
- On-going assistance, counseling and guidance once the business has launched

Supported Employment services are provided only at work sites where persons without disabilities are employed. When Supported Employment services are provided at a work site where persons without disabilities are also employed, payment will be made only for the adaptations, supervision, and training required by participants receiving ID/DD Waiver services, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported Employment services are not available under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

General guidelines for Supported Employment include the following:

- Personal care/assistance may be a component of Supported Employment, but it may not comprise the entirety of the service.
- Services do not include sheltered work or other similar types of vocational services furnished in specialized facilities.

- Medicaid funds will not be used to defray the expenses associated with starting or operating a business.
- Participants receiving Supported Employment may also receive educational, Prevocational, Day Services for adults, In-home Respite, Community Respite, ICF/MR Respite, Home and Community Supports, Behavior Support/Intervention services, and/or PT/OT/ST if the services are included in the approved POC. None of these services may be received during the same time period but a participant can receive multiple services on the same day. Exception: Behavior Support/Intervention services may be provided simultaneously with Supported Employment.

Transportation between the participant's residence and/or other habilitation sites and the employment site is a component part of Supported Employment. The cost of transportation is included in the rate paid to the provider. Providers should not bill separately for transportation services and should not charge participants for these services

### **Home and Community Supports**

Home and Community Supports (HCS) are a range of services for participants who require assistance to meet their daily living needs. Services ensure the participant can function adequately both in the home and in the community. Services also provide safe access to the community. HCS may be provided in a participant's private residence (own home or family home) and/or community settings.

Services include the following:

- Hands-on assistance or cuing/prompting the participant to perform a task.
- Accompanying and assisting the participant in accessing community resources and participating in community activities.
- Medication administration and other medical treatments to the extent permitted by current State law.
- Supervision and monitoring in the participant's home, during transportation, and in the community setting.
- Provision for and/or assistance with housekeeping that is directly related to the participant's disability and is necessary for the health and well-being of the participant (this may not comprise the entirety of the service).
- Assistance with money management, but not receiving or disbursing funds on behalf of the participant.

- Grocery shopping, meal preparation and assistance with feeding not to include the cost of meals themselves.

General guidelines for Home and Community Supports include the following:

- HCS cannot be provided in school or be used as a substitute for educational services.
- HCS may be provided on an episodic or regularly scheduled basis.
- HCS cannot be provided to a participant who lives in a residential setting or who is an inpatient of a hospital, nursing facility, or ICF/MR if the facility is billing Medicaid, Medicare, and/or private insurance.
- Participants receiving HCS may also receive educational, Prevocational, Day Services for adults, In-Home Respite, Community Respite, ICF/MR Respite, Behavior Support/Intervention services, and/or PT/OT/ST if the services are included in the approved POC. Even though a participant may receive multiple services on the same day, services may not be received during the same time period. Services provided during the same time period will be considered duplication of services. If duplication of services is discovered, all providers involved will be subject to investigation by DOM Bureau of Program Integrity. Providers will make all records that will disclose services rendered and/or billed under the program, upon request, available to representatives of CMS, DOM, the Attorney General Medicaid Fraud Control Unit, or DHHS in substantiation of any and all claims.
- Providers are not required to transport participants to the community. However, community integration is a component part of home and community supports and transportation is allowable as part of the service.

### **Behavior Support/Intervention**

Behavior Support/Intervention is provided for beneficiaries who exhibit behavior problems that prevent them from benefiting from other services being provided or cause them to be so disruptive in their environment(s) that there is imminent danger of removal or dismissal. The provider works directly with the beneficiary and trains staff and family members to assist in the implementation of specific behavior support/intervention programs. Services are limited to a maximum of ten (10) hours per year for evaluation and eight hundred (800) hours per year for direct services.

Services may be provided in the home, in a habilitation setting, or the provider's office. Services cannot be provided in a public school setting. The provider may observe the beneficiary in the school setting to gather information, but may not function as an assistant in the classroom by providing direct services.

Behavior Support/Intervention is not available under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) or through the Expanded Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

Behavior Support/Intervention services may include the following:

- Assessing the beneficiary's environment and identifying antecedents of particular behaviors, consequences of those behaviors, maintenance factors for the behaviors, and in turn how these particular behaviors impact the beneficiary's environment and life
- Developing a behavior support plan, implementing the plan, collecting the data, measuring outcomes to assess the effectiveness of the plan, and training staff and/or family members to maintain and/or continue implementing the plan
- Providing therapy services to the beneficiary to assist him/her in becoming more effective in controlling his/her own behavior either through counseling or by implementing the behavior support plan
- Communication with medical and ancillary therapy providers to promote coherent and coordinated services addressing behavioral issues in order to limit the need for psychotherapeutic medications

### **Therapy Services (Physical Therapy, Occupational Therapy, Speech-Language Therapy)**

Therapy services (physical therapy, occupational therapy, and speech-language pathology) are covered under the State Plan until the participant reaches maximum health care goals or no longer meets medical necessity criteria for prior authorization/pre-certification from the Utilization Management and Quality Improvement Organization (UM/QIO) for DOM.

Therapy services provided through the waiver begin at the termination of State Plan services. ID/DD Waiver therapy services are not available under the Individuals with Disabilities Education Act(20 U.S.C. 1401 et seq.) or through EPSDT/Expanded EPSDT and are in excess of those covered under the State Plan, either in amount, duration or scope. Services are considered to be both cost-effective and necessary to prevent institutionalization. Services are limited as follows:

- Speech-language pathology: maximum of three (3) hours per week
- Physical therapy: maximum of three (3) hours per week
- Occupational therapy: Maximum of two (2) hours per week

Therapy providers (individual and/or facility) must meet state and federal licensing/certification requirements.

**Specialized Medical Supplies**

Specialized Medical Supplies are those supplies available under the waiver to beneficiaries who are not covered for such supplies under regular State Plan benefits. Refer to Provider Policy Manual Section 10.0 for Durable Medical Equipment policy.

When specialized medical supplies are not available or have been exhausted under the regular State Plan services, they may be covered through the ID/DD Waiver if they are on the participant's current approved POC. The following list includes supplies covered under the waiver, if they are on the approved POC:

- Specified types of catheters
- Diapers
- Under pads

DME providers must meet state and federal licensing/certification requirements.

All ID/DD Waiver services and supplies must be included in the participant's Plan of Care.

**Reporting of Critical Events**

<b>Event</b>	<b>Legal Representative</b>	<b>DMH/OCS</b>	<b>MSDH</b>	<b>DHS/DFCS</b>	<b>AGs Office (VAU/MFCU)</b>
Suicide Attempt on program property of program – sponsored event	ASAP, but within 24 hrs	Phone ASAP, but within 24 hours or next business day. Report within 5 business days			
Suspected abuse/neglect/exploitation of a participant	ASAP, but within 24 hrs	Phone ASAP, but within 24 hours or next business day. Report within 5 business days	*	*	*
Unexplained absence from a residential program of twenty-four (24) hour duration	ASAP, but within 24 hrs	Phone ASAP, but within 24 hours or next business day. Report within 5 business days			
Absence of any length of	ASAP, but within	Phone ASAP,			

time from an adult day center providing services to individuals with Alzheimer’s disease and/or other dementia (i.e. wandering away from the premises)	24 hrs	but within 24 hours or next business day. Report within 5 business days			
Death of a participant on program property, at a program-sponsored event or during an unexplained absence from a residential program site	ASAP, but within 24 hrs	Phone ASAP, but within 24 hours or next business day. Report within 5 business days			
Emergency hospitalization or emergency room treatment of a participant receiving ID/DD Waiver services	ASAP, but within 24 hrs	Phone ASAP, but within 24 hours or next business day. Report within 5 business days	*	*	*
Accidents which require hospitalization and may be related to abuse or neglect, or in which the cause is unknown or unusual.	ASAP, but within 24 hrs	Phone ASAP, but within 24 hours or next business day. Report within 5 business days	*	*	*
Use of seclusion or restraint	ASAP, but within 24 hrs	Phone ASAP, but within 24 hours or next business day. Report within 5 business days	*	*	*
Disasters such as fires floods, tornadoes, hurricanes, earthquakes, disease outbreaks, etc.	ASAP, but within 24 hrs	Phone ASAP, but within 24 hours or next business day. Report within 5 business days	*		

## Grievances and Complaints

Mississippi Code, Section 41-4-7, parts (q) and (y) gives authority for the operation of a grievance/complaint system to the Mississippi State Board of Mental Health. The Department of Mental Health, Office of Constituency Services (DMH/OCS) is responsible for investigating and documenting all grievances/complaints regarding all programs operated and/or certified by DMH. The DMH, Office of Constituency Advisory Council assists the OCS in development of

procedures for receiving, investigating, and resolving the grievances/complaints. Personnel issues are not within the purview of DMH/OCS.

A toll-free Helpline is available twenty-four (24) hours a day, seven (7) days per week. The line is answered by OCS staff from 8 a.m. until 5 p.m. during business days. After hours, on weekends and state holidays, trained contract staff answers the line. As a condition of DMH certification, all providers are required to post the toll-free number in a prominent place throughout each program site.

### **Provider Certification Decisions**

Providers who must be certified by the Mississippi Department of Mental Health, Bureau of Intellectual Disabilities and Developmental Disabilities (DMH/BIDD) may appeal certification decisions to DMH. Certification is dependent upon compliance with the Mississippi Department of Mental Health Standards. The standards also address the appeals process. A web copy may be found at <http://www.dmh.state.ms.us>. Click on the link for online documents.

## **Prior Authorization**

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Prior Authorization is not required for ID/DD waiver.

## **On-Site Compliance Review (OSCR)**

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### **Purpose**

The purpose of an on-site compliance review is to verify that each ID/DD Waiver provider is in compliance with applicable state and federal requirements and to monitor the quality of treatment being provided to Medicaid beneficiaries.

### **Goals**

- To assess the program and services offered by the ID/DD Waiver provider through direct observation, document review, staff interviews, participant interviews and family interviews.
- To provide clear, specific feedback regarding review findings to ID/DD Waiver providers in order that services may be enhanced.

### **Review Team Composition**

The review team will be comprised of at least two (2) but no more than five (5) DOM staff and consultants, including an identified team leader, who will be a full-time DOM staff person.

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### **Pre-Review Notification**

Written notification of an upcoming OSCR will be provided to the ID/DD Waiver provider seven (7) to ten (10) days prior to the time the OSCR is scheduled to begin. The notification will include:

- The anticipated schedule for the OSCR
- The names of the participating team members
- A list of documents to be reviewed

Upon receipt of its pre-review notification, the ID/DD Waiver provider will contact DOM to verify awareness of the upcoming OSCR.

### **Overview of OSCR Process**

The OSCR process is intended to monitor an ID/DD Waiver provider's overall operations for compliance with legal requirements and for quality of clinical programs and services. The review inquiries into the ID/DD Waiver provider's operations in three domains:

- **Administration:** This area comprises the organizational structure and management of the ID/DD Waiver program. Administrative functioning is evaluated through the review of such information as policy and procedure manuals, staff credentials and training, utilization review documents, incident reports, etc.
- **Program:** This area comprises the philosophy and structure of the ID/DD Waiver provider's approach to treatment (what they believe constitutes good treatment and how they plan to carry it out). The program is evaluated through the review of program policy and procedure manuals, staff training schedules, and staff interviews.
- **Services:** This area comprises the manner in which an ID/DD Waiver translates into services provided to beneficiaries. The team particularly looks at whether or not services are delivered in such a manner as to provide maximum benefit to each beneficiary. Special emphasis is placed on the Plan of Care (POC) and case management.

The frequency with which routine reviews are scheduled is dependent upon the status of the provider at the time of its last review. Generally, the higher the provider's rating, the longer the period of time between reviews. Refer to the ID/DD Waiver provider Status Categories below for applicable time frames. Routine OSCRs will almost always be full-scale reviews, with every aspect of the ID/DD Waiver provider being evaluated.

Reviews are conducted utilizing the following Compliance Review Instruments (CRI) which can be viewed on the DOM Mental Health Services website under the ID/DD Waiver section:

- DMH Document Review
- Regional Center Document Review
- Staff Interviews
- Home Visit
- Individual Record Review

At the discretion of DOM, an OSCR may be conducted as a partial off-site (review of records) and partial on-site (staff/participant/family interviews) compliance review.

### **General Outline of OSCR Process**

- **Entrance Interview:** At the beginning of the OSCR, the review team will meet with a small group (not to exceed six (6) people) of staff selected by the ID/DD Waiver provider for an overview of the OSCR process. The group will typically consist of the Support Coordination Director, Agency Director and direct care providers. The entrance interview is the provider's opportunity to meet the review team, inform the team of any changes in the program that have occurred since the last review and to ask questions about the current proceedings. This phase typically will last thirty (30) minutes or less.
- **Review of Administrative and Program Records:** The review team will review administrative and program documents requested in the pre-OSCR notification.
- **Review of Participant Records:** Randomly selected participant records will be reviewed by the team to assess compliance with DMH Standards and Record Guide and DOM ID/DD Waiver policy.
- **Staff Interviews:** Staff to be interviewed will be identified during the course of the OSCR. The team is particularly interested in how well program guidelines are carried out in practice and whether or not staff work together collaboratively, functioning as a true team.
- **Participant and Family Interviews (Home Visit):** Prior to the site visit, the review team will identify participants and families to be interviewed separately. Interviews will typically occur in conjunction with a home visit or, if not possible, at an appropriate location convenient for the participant and family. The ID/DD Waiver provider will coordinate home visits and interviews with the review team. The review team will assess if the participant/family feels they are actively involved in their treatment, how knowledgeable they are about specific aspects of their services, and how they view the program and staff's ability to help them.

- **Review Team Conference (Status rating):** At the conclusion of the above components, the review team will meet in private to compile all information and prepare for the Exit Interview.
- **Exit Interview:** The review team will meet with the ID/DD Waiver staff to present an overview of the team's findings and inform the provider of its current ID/DD Waiver status. At this time staff may ask questions, request examples of problems cited, etc. The same representatives who were present at the Entrance Interview will attend unless changes have been discussed with the review team leader. This phase typically will last one (1) hour or less.
- **Written Report (Compliance Review):** The DOM will provide the ID/DD Waiver provider with a written report of the review team's findings at the conclusion of the OSCR. If the status ruling is Commendation or Approved, the OSCR process is complete until the next routine OSCR. The provider must submit a Corrective Action Plan (CAP) to DOM for all items cited in the OSCR.

### **ID/DD Waiver Status Categories**

At the time of the Exit Interview, the ID/DD Waiver provider will be informed of its status category. The status categories are as follows:

1. **Commendation:** Program and services consistently exceed standards
  - No problems were cited by the review team
  - The next OSCR will be scheduled in approximately eighteen (18) months.
2. **Approved:** Program and services consistently meet standards
  - No citations in areas that reflect on safety/well-being of waiver participants
  - The next OSCR will be scheduled in approximately one (1) year.
3. **Review:** Overall program and services are of acceptable quality with one (1) or more specific areas of substandard quality
  - If there were no citations, the next OSCR will be scheduled in approximately six (6) months
  - If problems were cited, a CAP must be submitted to address them and the next OSCR will be scheduled in approximately six (6) months after the implementation of an approved CAP

**4. Probation:**

- Program and services are of substandard quality or
- The provider is already on Review Status and has failed to show improvement in a follow-up OSCR or
- Conditions exist which could jeopardize the safety or well-being of a participant.
- A CAP must be submitted to address all identified concerns
- The next OSCR will be scheduled in approximately three (3) months after implementation of an approved CAP

**5. Suspension:**

- Program and services are of unacceptable quality or
- Conditions exist which jeopardize the lives or well-being of beneficiary or families
- Admissions of Medicaid beneficiaries are suspended until further notice
- The next OSCR will be scheduled as soon as reasonably possible (no later than thirty (30) days) after the implementation of an approved CAP.

**6. Deferred:**

- If the review team requires additional information or expert opinion in order to complete its determination, then the status ruling may be deferred
- In cases of deferred status, the DOM must re-contact the ID/DD Waiver provider within ten (10) days and
  - Request additional information or documentation, which must then be provided by the PRTF within ten (10) days of receiving the request and/or
  - Schedule a continuation of the OSCR, in which case additional team members may participate in further on-site review of the facility or
  - Submit a final status ruling
  - The ten (10) day request/submission response cycle will continue until a

final status determination is made

### **Corrective Action Plan (CAP)**

Any ID/DD waiver provider receiving a rating of Review, Probation or Suspension must submit a Corrective Action Plan (CAP). The CAP must be received by DOM no later than ten (10) working days following the ID/DD waiver provider's receipt of its status ruling.

The CAP must address separately each concern cited in the OSCR report by:

- Proposing specific actions that will be taken to correct each identified problem
- Specifying an implementation date for each corrective action
- Including supporting documentation as appropriate, e.g. policy or procedural changes, new or revised forms, copies of schedules of training or staffing, etc.

Justifications or explanations for the cited problems have no place in the CAP. Although there may be good reasons for the existence of the problems, DOM is interested only in the proposed solutions. The narrative of the CAP should be succinct and to-the-point. The following format is suggested for each separate element cited:

- Description of element
- Findings
- Plan of correction
- Implementation date
- Supporting documentation (attached to the CAP and referenced in the narrative response)

### **Examples:**

- Description of element: Plan of Care contains approved hours
- Findings: Approved hours were not updated in the most recent POC of two (2) charts reviewed
- Plan of correction: Support Coordination Director will provide in-service training to Support Coordinators on record documentation. Plan of care will be reviewed for completeness through record audits by Support Coordination Director.
- Implementation Date: July 1, 2011

- Supporting documentation: Attachment A: Training logs.

The CAP will include the name and telephone number of a provider staff member who will work with DOM towards approval of the CAP.

The DOM must approve/disapprove of the provider's proposed CAP within ten (10) working days of its receipt by DOM. The ten (10) day submission/ten (10) day response cycle will continue until DOM approves a CAP. The provider must implement the CAP within thirty (30) days of its approval. When notifying the provider of its CAP approval, the DOM will also inform the provider of the anticipated time of the next follow-up OSCR.

### **Appeals Process**

If the ID/DD Waiver provider disagrees with its status ruling or has a complaint regarding DOM's response to the proposed CAP, the concerns should be addressed as follows:

Division of Medicaid  
Bureau of Mental Health Programs  
Director, Mental Health Services

If the ID/DD Waiver provider disagrees with the response to its appeal, the concerns should be addressed as follows:

Division of Medicaid  
Director, Bureau of Mental Health Programs

If the ID/DD Waiver provider disagrees with the results of this appeal, it should address its concerns to:

Division of Medicaid  
Deputy Administrator, Bureau of Health Services

If the ID/DD Waiver provider disagrees with the results of this appeal, it should address its concerns to:

Division of Medicaid  
Executive Director

Address all correspondence to:

Division of Medicaid  
Walter Sillers Building  
550 High Street, Suite 1000  
Jackson, MS 39201